No. 88-1503

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L. AND JOYCE CRUZAN,

Petitioners,

v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,

Respondents,

v.

THAD C. MCCANSE, GUARDIAN AD LITEM,

Respondent.

On Writ of Certiorari to the Missouri Supreme Court

BRIEF OF JAMES DUNLAP AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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MOTION FOR LEAVE TO FILE A BRIEF AS AMICUS CURIAE ON BEHALF OF RESPONDENT

Amicus hereby respectfully moves for leave to file a brief amicus curiae in the present case. Requested consent of the parties is expected but has not yet been received and filed. When filed, it will make this motion unnecessary.

INTEREST OF AMICUS CURIAE

James Dunlap is an ordinary citizen from Detroit who has had a great interest in respect for human life for about twenty years.

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SUMMARY OF ARGUMENT

President Reagan chose for his Surgeon General C Everett Koop. It was stated at the time of the appointment that Mr Reagan had chosen Dr Koop in part because of Dr Koop's long advocacy of respect for human life, especially that human life which has been damaged and that human life which many in the medical profession wish to kill. The article from which this brief is taken was first given as an address by Dr Koop to The American Academy of Pediatrics, on the occasion of his being awarded the William E Ladd Medal, the highest honor given to pediatric surgeons in America. It was printed in the Human Life Review, spring, 1977, and may have been part of the reason why Dr Koop was chosen to be Surgeon General. It certainly was part of the reason for opposition to his

appointment.

In 1983, President Reagan in an unprecedented action published in The Human Life Review an anti abortion article entitled: "Abortion and the Conscience of the Nation". In 1984, the same article was published by Mr Reagan as part of a book by the same name. The book, "Abortion and the Conscience of the Nation" included two other sections. The second section was by Dr Koop and comprises this brief. It strongly urges that no action be taken to strip away any of the protections against euthanasia of the handicapped. While written before Nancy Cruzan's accident, it is a relevant and urgent plea that this Court take no action similar to reversing this case because such action might begin a "subtle, slippery slide to Auschwitz".

THE SLIDE TO AUSCWITZ

by C EVERETT KOOP from

ABORTION AND THE CONSCIENCE OF THE NATION

In July the City Council of Cambridge, Massachusetts, voted to petition Harvard University to temporarily halt the construction of a half million dollar laboratory for specialized genetics research. This intervention of the town in the affairs of the University was not just the hysterical reaction of ignorant people to the misunderstood pursuits of a scientific faculty. Rather, it had been initiated and pushed by distinguished scholars on the Harvard faculty. These individuals were deeply concerned with the newly acquired power in biology to alter the genes of living organisms and create new hybrids of animals and plants, and of viruses, some of them potentially dangerous.

It is the custom of men to be concerned about those things of which they know little at present but where the potential seems to be a threat to all of mankind. This was true of the first atomic bomb; of its successor, the hydrogen bomb; of all the weaponry to deliver thermonuclear warfare; of biological warfare and of nerve gas. There are even environmentalists who are deeply concerned over the destruction of the ozone by aerosol cans. Yet, each of these potential dangers to mankind is theoretically, if not practically, controllable.

I would like to address you today on another potentially destructive force against mankind which, because of the nature of human beings, may not be controllable until it has inexorably pursued its path of destruction and has come to weigh upon the conscience of so many people

that, like a Vietnam war, it must grind to a halt. I am speaking of the growing disregard for life itself. I am speaking of what was called in a more moral, or perhaps a more religious generation, the sanctity of human life. Given the conflicting concerns of our generation – the specter of famine raised by those primarily concerned about population control, the specter of financial chaos for the whole world raised by economic pundits, the intrusion of violence as an accepted thing into our culture, and the declining morality in all the affairs of men – it is quite possible that when the inevitable swing of the pendulum takes place and life once again becomes precious, it might be too late to stop the slide that will ultimately herald the decline and demise of our civilization.

I am nearing the end of my thirty-first year in the actual practice of pediatric surgery, longer I think than anyone in this room today. I have had the unusual advantage of growing up with my specialty. It has been for me an extremely satisfying career. One of the most satisfying aspects has been my participation in the rehabilitation of youngsters who were born with congenital anomalies incompatible with life but nevertheless amenable to surgical correction. The surgical correction might have been by a dramatic one-stroke procedure or it may have required years of time and effort, plus further operations, to get the best possible result. At times the best possible result was far from perfect. Yet, I have a sense of satisfaction in my career, best indicated perhaps by the fact that no family has ever come

to me and said: "Why did you work so hard to save the life of my child?" And no grown child has ever come back to ask me why, either. On the other hand, in a recent study that I did on twenty-five families, all of whom had had a child with an imperforate anus operated upon by me in the period twenty-five to fifteen years ago, almost every family referred to the experience of raising the defective youngster as a positive one. A few were neutral; none were negative. Some siblings felt that they had not had some of the advantages that they might have had if their brother or sister had been born normal, yet on balance the conclusion from these twenty-five families whom we studied quite extensively was that many of them were better families than they would have been without the neces-

sity of facing the adversity produced by the problems of the imperfect child.

I do not think that I am over the hill, but with mandatory retirement less than five years away it does behoove me to look at the end of my career. As I do it saddens me. But it frightens me too when I see the trends in our society and recognize the acquiescence, if not the *leadership,* of the medical profession down a path which in my judgment leads to destruction.

In January of 1973 the United States Supreme Court declared that a new right existed in the Constitution; namely, the right of a woman to have an abortion on demand. I am not here today to argue the pros and cons of the abortion question, but in a paper I presented in 1973, I predicted ten consequences of the Supreme Court's decision on abortion that would

remarkably – deleteriously–affect the society in which we live.[1] All ten of these prophetic statements have found realization in historical fact.

Without going into all the details, I expressed the concern that abortion of somewhere between a million and two million unborn babies a year would lead to such cheapening of human life that infanticide would not be far behind. Well, you all know that infanticide is being practiced right *now* in this country and I guess the thing that saddens me most about *that* is that it is being practiced by that very segment of our profession which has always stood in the role of advocate for the lives of children.

I am frequently told by people who have never had the experience of working

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[1] C. E. Koop, "Of Law, of Life, and the Days Ahead," Wheaton College Graduation Address, June, 1973

with children who are being rehabilitated into our society after the correction of a congenital defect that infants with such defects should be allowed to die, or even "encouraged" to die, because their lives could obviously be nothing but unhappy and miserable. Yet it has been my constant experience that disability and unhappiness do not necessarily go together. Some of the most unhappy children whom I have known have all of the physical and mental faculties and on the other hand some of the happiest youngsters have borne burdens which I myself would find very difficult to bear. Our *obligation* in such circumstances is to find alternatives for the problems our patients face. I don't consider death an acceptable alternative. With our technology and creativity, we are merely at the beginning of what we can do educa-

tionally and in the field of leisure activities for such youngsters. And who knows what happiness is for another person? What about the rewards and satisfactions in life to those who work with and succeed in the rehabilitation of these "other-than-perfect" children? Stronger character, compassion, deeper understanding of another's burdens, creativity, and deeper family bonds – all can and do result from the so-called social "burdens" of raising a child with a congenital defect – repaired but less than perfect.

I have frequently said, facetiously, that nothing makes a woman out of a girl quicker than a colostomy in her child. But it is true.

When from the materialistic point of view a life seems to be without meaning, it can from the spiritual point of view

be extremely useful. Such a life might, for example, provide a source of courage in the manner in which the stress caused by disease and its treatment is accepted. There is also no doubt that the value placed upon the patient by his associates as one who is respected and honored and loved is a source of inspiration to all who see it and a spiritual blessing to many.

"American opinion is rapidly moving toward the position where parents who have an abnormal child may be considered irresponsible." This is the observation of Dr. James Sorenson, Associate Professor of Socio-Medical Sciences at Boston University, who spoke at a symposium, "Prenatal Diagnosis and Its Impact on Society."[1]

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1 *Newsletter* of American Association of Pro-Life Obstetricians and Gynecologists, ed. Dr.

Now, if I take a strong stand against a statement like Dr. Sorenson's, I am told that I am trying to legislate my morality for other people. I think, on the contrary, those who agree with Dr. Sorenson's statement are trying to legislate the morality of our society. Parents who might give remarkable love and devotion to an abnormal child are put in the position of feeling they must conform to Dr. Sorenson's morality, or lack of it, for the good of *society* rather than for the good of their own child.

In the book, *Ideals of Life*, Millard Everett writes:

> *No child [should] be admitted into the society of the living who would be certain to suffer any social handicap –*

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footnote continued:
Matthew Bulfin, Ft. Lauderdale, Florida, August, 1976.

for example, any physical or mental defect that would prevent marriage or would make others tolerate his company only from the sense of mercy.[1]

If dehumanization is one of the ideals of life, then when we reach the utopia planned by Mr. Everett, life will be ideal indeed. His reference to marriage I cannot help but consider because I am convinced that the backbone of our remarkable nursing profession and that much of our pediatric care and pediatric social service are to be found in the many unmarried women who devote themselves selflessly to the care of patients. I cannot believe that all of these fine women *chose* not to be married merely to take care of patients. It

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[1] Quoted by Leah Curtin in her address "On Dehumanization" on behalf of the National Center for Nursing Ethics, Cincinnati, Ohio, in July, 1976, at Boston University.

would follow then that there might have been some "social handicap," to use the words of Millard Everett, that might have prevented marriage. If the social handicap existed then, the social handicap must exist today. How long will it be before the Millard Everetts of our society decide that those with this social handicap, whatever it might be, be eliminated also?

Lord Cohen of Burkenhead, speaking of the possibility of euthanasia for children in Great Britain who were mentally defective or epileptic, said:

No doctor could subscribe to this view … who has seen the love and devotion which bring out all that is the best in men when lavished on such a child.[1]

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[1] Quoted from P. P. Rickham's discourse "The Swing of the Pendulum," on occasion of the Centennial Celebration of the Children's Hospital in Sheffield, England, July, 1976.

J. Engelbert Dunphy, in the annual oration before the Massachusetts Medical Society in 1976, had this to say:

We cannot destroy life. We cannot regard the hydrocephalic child as a non-person and accept the responsibility for disposing of it like a sick animal. If there are those in society who think this step would be good, let them work for a totalitarian form of government where beginning with the infirm and incompetent and ending with intellectually dissident, non-persons are disposed of day and night by those in power.

Dunphy goes on to say:

History shows clearly the frighteningly short steps from "the living will" to "death control" to "thought control" and finally to the systematic elimination of all but those selected for slavery or to make up the master race. We physi-

cians must take care that support of an innocent but quite unnecessary "living will" does not pave the way for us to be the executioners while the decisions for death are made by a panel of "objective experts" or by big brother himself. The year of 1984 is not far away![1]

Dr. Dunphy was speaking of adults dying of terminal cancer, yet his thinking can be extrapolated to the "imperfect" child with frightening consequences.

In the Forshall lecture given by Robert B. Zachary on July 9, 1976, in Sheffield, England, he said:

I accept that the advice given by other doctors may well be different from that which I myself give, and although I would strongly support their right to

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1 J. E. Dunphy, "On Caring for the Patient with Cancer," *New England Journal of Medicine*, August 5, 1976, 295:313.

have a different view, they should be expected to state the fundamental principles on which their criteria are based.

Zachary went on to state:

I believe that our patients, no matter how young or small they are, should receive the same consideration and expert help that would be considered normal in an adult. Just because he is small, just because he cannot speak for himself, this is no excuse to regarding him as expendable, anymore than we would do so on account of race or creed or color or poverty. Nor do I think we ought to be swayed by an argument that the parents have less to lose because he is small and newborn, and has not yet established a close relationship with them or indeed because the infant himself does not know what he is losing, by missing out on life.

Mr. Zachary concluded his lecture:

There are some ways in which modern society cares greatly about those who are less well off; the poor, the sick and the handicapped, but it seems to me that newborn babies are often given less than justice. Our primary concern must be the well-being of the patient – the neonate – as far as it is in our power to achieve it. In his battle at the beginning of life, it could well be that his main defense will be in the hands of pediatric and neonatal surgeons.

Has not Mr. Zachary enunciated the whole *raison d'etre* of the specialty of pediatric surgery?

On the occasion of the one hundredth anniversary of the Children's Hospital in Sheffield in July of 1976, Mr. Peter Rickham of Zurich presented a paper entitled "The Swing of the Pendulum."

Although he concerned himself largely with the problems of meningomyelocele (a birth defect where the spinal cord is exposed, leading to neurological *sequellae*, some correctable and some not), an ethical problem of greater proportion in the British Isles than here, he did talk to some degree on medical ethics in reference to the neonate. In discussing his own interviews with theologians of diverse religious convictions, he had this to say.

They all doubt the validity of the basis of the present argument for selection of only the least handicapped patients for survival. The hope that selection will reduce to a minimum the overall suffering of these patients and their families is a well meant but somewhat naive wish. How many normal newborn infants will live happily ever after,

especially in our present time? It may be argued that by not selecting, we artificially increase the number of people with an unhappy future, but can we be sure of this in any given case? After all we as doctors deal with single, individual patients and not with statistical possibilities. It has also been pointed out to me (said Rickham) *that even a child with a grave physical and mental handicap can experience emotions such as happiness, fright, gratitude and love and that it may be therefore, in fact, a rewarding task to look after him. It has been further argued that, strictly speaking, selection implies a limitation of resources, because with an optimum of resources and care a great deal can be done for these children and their families. In underdeveloped countries these resources do not exist, but in developed*

countries, where such enormous sums are spent by governments on purposes which are of very doubtful benefit to humanity at large, the distribution of resources is a debatable subject. Finally it can be argued that if selection is practiced, it may not be necessarily the fittest on whom the greatest effort should be expended.

Duff and Campbell in their paper on moral and ethical dilemmas in the special care nursery make the statement that "survivors of these (neonatal intensive care) units may be healthy and their parents grateful but some infants continue to suffer from such conditions as chronic cardiopulmonary disease, short bowel syndrome, or various manifestations of brain damage; others are severely handicapped by a myriad of congenital malformations

that in previous times would have resulted in early death."[1]

First of all, it is not necessarily true that the myriad of congenital malformations of previous times would now result in early death. Many patients who have lesions corrected and although they may not be pristine in their final form they are functional human beings, loved and loving and productive. If indeed we decide that a child with a chronic cardiopulmonary disease or a short bowel syndrome or various manifestations of brain damage should be permitted to die by lack of feeding, what is to prevent the next step which takes the adult with chronic cardiopulmonary disease who may be much more of a burden to his family

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1 R. S. Duff and A. G. Campbell, "Moral and Ethical Dilemmas in the Special-Care Nursery," *New England Journal of Medicine,* October 25, 1973, 289:890.

than that child is, or the individual who may not have a short bowel syndrome but who has ulcerative colitis and in addition to his physical manifestations has many psychiatric problems as well or the individual who has brain damage – do we kill all people with neurological deficit after an automotive accident?

Very, very few parents of their own volition come to a physician and say, "My baby has a life not worthy to be lived." Any physician in the tremendously emotional circumstances surrounding the birth of a baby with any kind of a defect can, by innuendo, let alone advice, prepare that family to make the decision that that physician wants them to make. I do not consider this to be "informed consent."

Campbell and Duff say this: "Often, too, the parents' and siblings' rights to

relief from seemingly pointless, crushing burdens were important considerations." Here again Duff and Campbell have enunciated a new right and that is that parents and siblings are not to have burdens. Even Duff and Campbell use the word "seemingly" in reference to "pointless" and I am sure that "crushing" as applied to the burden may not be nearly as crushing as when applied to the eventual guilt of the parents in days to come.

As partial justification for their point of view, Duff and Campbell say that although some (parents) have exhibited doubts that the choices were correct, all appear to be as effective in their lives as they were before this experience. Some claim that their profoundly moving experience has provided a deeper meaning in life and from this they believe they have become more effective people.

If these same parents were seeking deeper meaning in life and if Duff and Campbell were indeed interested in providing deeper meaning in life for the parents of their deformed patients, why not let the family find that deeper meaning of life by providing the love and the attention necessary to take care of an infant that has been given to them? I suspect that the deeper meaning would be deeper still and that their effectiveness would be still more effective and that they would be examples of courage and of determination to others less courageous.

Duff and Campbell talk about "meaningful humanhood," a phrase which they extract from Fletcher, and of "wrongful life," a phrase which they take from Engelhart. As soon as we let anyone, even physicians, make decisions about your humanhood and mine, about your

rightfulness or wrongfulness of life and mine, then we have opened the door to decisions being made about our worth which may be entirely different in the eyes of a Duff and a Campbell or their followers than it would be in yours and mine.

In their discussion, Duff and Campbell say that parents are able to understand the implications of such things as chronic dyspnea, oxygen dependence, incontinence, paralysis, contractures, sexual handicaps, and mental retardation. Because a newborn child has the possibility of any of these problems in later life, does this give us the right to terminate his life now? If it does, then I suspect that there are people in this room who have chronic dyspnea, who may have oxygen dependency at night, who might be incontinent, who may have a contracture, who may have a sexual handicap

and I trust that none of you are mentally retarded, but let's carry it to its logical conclusion. If we are going to kill the newborn with these potentials, why not you who already have them?

Finally Duff and Campbell say, "It seems appropriate that the profession be held accountable for presenting fully all management options and their expected consequences." I wonder how commonly physicians who opt for starving a baby to death are willing to be held accountable for the eventual consequences in that family which may not be apparent for years or decades to come.

I think the essential message in the Duff and Campbell paper is missed by many. These authors first brought to attention the concept of death as one of the options in pediatric patient care. But it is not always understood that the

death they presented as an option was not the death of infants who could not possibly survive but rather the death of infants who could live if treated, but whose lives would not be "normal." It is not the lesion, but the physician's *decision*, that is the lethal factor. In view of the fact that socio-economic status of the family, and the stability of the marriage, are mitigating circumstances in deciding on treatment or non-treatment, it is clear that there has been introduced a discrimination just as deplorable as those of race, creed, or color, of which we are constantly reminded. I wonder how many of us would be here today if someone had the option of not feeding us as newborns?

Arthur Dyck, who has the intriguing title of Professor of Population Ethics at the Harvard School of Public Health,

is also a member of the faculty at the Divinity School at Harvard. The connotation of being a Professor of Population Ethics these days, even with a seminary appointment, would lead one to expect that such a man would be ready and willing to eliminate all life that was not "meaningful"—a word I detest. Yet, Professor Dyck believes much more in the *equality* of life than he does in the *quality* of life; he believes that we should and must minister to the maimed, the incompetent, and the dying. To put it in his words:

The moral question for us is not whether the suffering and the dying are persons but whether we are the kind of persons who will care for them without doubting their worth.[1]

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[1] A. J. Dyck, "The Value of Life: Two Contending Policies," *Harvard Magazine*, January, 1970, pp. 30-36.

We in the medical profession have traditionally responded in our treatment of patients as a reflection of our society's human concern for those who are ill or helpless. Indeed we have often acted as advocates for those who had no one else to stand up for them. Thus we have always responded, in days gone by, with love and compassion toward the helpless child. It may well be that our technical skills have increased too rapidly and indeed have produced dilemmas that we did not face a decade ago. But this does not give us any new expertise in deciding who shall live and who shall die, especially when so many non-medical factors must be taken into account in making the decision.

It is really not up to the medical profession to attempt to alleviate all of the injustice of the world that we might

see in our practice in the form of suffering and despair. We can always make the effort to alleviate the pain of the individual patient and to provide the maximum support for the individual family. If we cannot cure, we can care, and I don't mean ever to use the words "care" and "kill" as being synonymous.

Leo Alexander, a Boston psychiatrist, was at one time (1946-47) consultant to the Secretary of War on duty with the office of chief counsel for war crimes in Nuremberg. In a remarkable paper (which appeared in the *New England Journal of Medicine*, July 4, 1949), "Medical Science Under Dictatorship," he outlined the problem.[1] Let me just mention the highlights of Dr. Alexander's presentation. The guiding philosophic

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[1] L. Alexander, "Medical Science Under Dictatorship," *New England Journal of Medicine*, July 4, 1949, 241:39-47.

principle of recent dictatorships, including that of Nazis, was Hegelian in that what was considered "rational utility" and corresponding doctrine and planning had replaced moral, ethical and religious values. Medical science in Nazi Germany collaborated with this Hegelian trend particularly in the following enterprises: the mass extermination of the chronically sick in the interest of saving "useless" expenses to the community as a whole; the mass extermination of those considered socially disturbing or racially and ideologically unwanted; the individual, inconspicuous extermination of those considered disloyal to the ruling group; and the ruthless use of "human experimental material" in medical military research. Remember, physicians took part in this planning.

Adults were propagandized; one outstanding example being a motion picture called "I Accuse," which dealt with euthanasia. This film depicted the life history of a woman suffering from multiple sclerosis and eventually showed her husband, a doctor, killing her to the accompaniment of soft piano music played by a sympathetic colleague in an adjacent room. The ideology was implanted even in high school children when their mathematics texts included problems stated in distorted terms of the cost of caring for and rehabilitating the chronically sick and crippled. For example, one problem asked how many new housing units could be built and how many marriage-allowance loans could be given newlyweds for the amount of money it cost the state to care for "the crippled, the criminal, and the insane." This was all before Hitler.

And it was all in the hands of the medical profession.

The first direct order for euthanasia came from Hitler in 1939. All state institutions were required to report on patients who had been ill for five years or more or who were unable to work. The decision regarding which patients should be killed was made entirely on the basis of name, race, marital status, nationality, next of kin, regularly visited by whom, and a statement of financial responsibility. The experts who made the decisions were chiefly professors of psychiatry in the key universities in Germany. They never saw the patients. There was a specific organization for the killing of children which was known by the euphemistic name of "Realms Committee for Scientific Approach to Severe Illness Due to Heredity and Constitution."

Transportation of the patients to the killing centers was carried out by the "Charitable Transport Company for the Sick." "The Charitable Foundation for Institutional Care" was in charge of collecting the cost of the killings from the relatives without, however, informing them what the charges were for.

Semantics can be a preparation for accepting a horror. When abortion can be called "retrospective fertility control," think of all the euphemisms for infanticide!

Although Leo Alexander said this in 1949, it applies today:

The case therefore that I should like to make is that American medicine must realize where it stands in its fundamental premises. There can be no doubt that in a subtle way the Hegelian premise of "what is useful is right" has infected

society including the medical portion of society. Physicians must return to their older premises, which were the emotional foundation and driving force of an amazingly successful quest to increase powers of healing and which are bound to carry them still farther if they are not held down to earth by the pernicious attitudes of an overdone practical realism.

I think those of you who graduated from medical school within ten to fifteen years of my time probably came out of that experience with the idea that you had been trained to save lives and alleviate suffering. The suffering you were to alleviate was the suffering of your patient and the life you were to save was the life of your patient. This has now become distorted in the semantics of the euthanasia movement in the following way:

You are to save lives; that is part of your profession. If the life you are trying to save, however, is producing suffering on the part of the family, then, they say, you are to alleviate that suffering by disposing of your patient. So in a strange way you can still say you are saving lives and alleviating suffering – but the practice of infanticide for the well-being of the family is a far cry from the traditional role of the pediatrician and more lately of the pediatric surgeon.

There are many times when I have operated upon a newborn youngster who subsequently dies, that I am inwardly relieved and express honestly to the family that the tragic turn of events in reference to life was indeed a blessing in disguise. However, being able to look on such an occasion in retrospect as a

blessing does not, I believe, entitle me to distribute showers of blessings to families by eliminating the problems that they might have to face in raising a child who is less than perfect.

We are rapidly moving from the state of mind where destruction of life is advocated for children who are considered to be socially useless or have non-meaningful lives to a place where we are willing to destroy a child because he is socially disturbing. What we need is alternatives, either in the form of education or palliative measures for the individual as well as for society. We here should be old enough to know that history does teach lessons. Destructiveness eventually is turned on the destroyer and self-destruction will be greater before the ultimate self-destruction brings an end to the holocaust.

The power to destroy our civilization and indeed our race is not necessarily good or bad in itself. The difficulty is to be certain that we have the moral character to use this power appropriately. Man's reaction to this kind of power can be either pride, man's greatest problem, or humility, one of man's most commendable virtues. Power accepted in humility is a source of strength for man's moral prerogatives.

We are an enthusiastic and an aggressive people and one of our tendencies is to make decisions on the basis of expediency – to take shortcuts to solutions, if you will. We must be very careful not to throw the baby out with the bathwater and I can't think of any situation where the use of that aphorism is more apropos because we are concerned with babies and we are indeed throwing

many babies out in what seems at first glance to be a commendable goal to make life easy for parents and to remove burdens from society.

I have not really chosen a title for these remarks although several have come to mind. The first is "The Camel's Nose is in the Tent," from the Middle Eastern proverb that when the camel's nose is in the tent, it is not long before he is in bed with you, and refers to the thin edge of the wedge in reference to euthanasia. The second that occurred to me, because I see the progression from abortion to infanticide, to euthanasia, to the problems that developed in Nazi Germany, and being aware of the appeal of alliteration in titles, is "Dominoes to Dachau." But having just visited Auschwitz in the company of some of my Polish confreres and having read extensively from the Germans'

own reports about what went on there, I view what we are experiencing now as a dynamic situation which can accelerate month by month until the progress of our downhill momentum cannot be stopped. Therefore, I guess I favor the title: "The Subtle, Slippery Slide to Auschwitz."

It is difficult to be a participant in history and understand what is going on with the same depth of perception that one would have if he were able to look back upon the present as an historian. The euthanasia movement – and I use that in the broadest possible sense–is with us today with greater strength and persuasion than ever has been the case before in the history of what we call modern civilization.

Do not dismiss contemptuously my concern in reference to the wedge princi-

ple – that when the camel gets his nose in the tent he *will* soon be in bed with you. Historians and jurists are well aware of what I am saying.

The first step is followed by the second step. You can say that if the first step is moral then whatever follows must be moral. The important thing, however, is this: whether you diagnose the first step as being one worth taking or being one that is precarious rests entirely on what the second step is *likely* to be.

My concerns center around several aspects of this issue. First of all, I have to say that I am proponent of the sanctity of life, of all life, born or unborn. I hate the term death with dignity because there is no dignity in death. I have many times withheld extraordinary measures from the care of my

patients who were terminal regardless of their age and have felt that I was doing the moral and the ethical as well as the just thing. I have never, on the other hand, taken a deliberate action to kill a patient whether this deliberate action was the administration of a poison or the withholding of something as ordinary as feeding that would keep him alive.

I am concerned about legislation that would take the problems of life and death out of the hands of the medical profession, and out of the realm of trust between the doctor and his patient or the patient's family, and put them into the legal realm.

Perhaps more than the law, I fear the attitude of our profession in sanctioning infanticide and in moving inexorably down the road from abortion to infanticide, to the destruction of a child

who is socially embarrassing, to you-name-it.

I am concerned that there is no outcry. I can well understand that there are people who are led to starve children to death because they think that they are doing something right for society or are following a principle of Hegel that is utilitarian for society. But I cannot understand why the other people, and I know that there are many, don't cry out. I am concerned about this because when the first 273,000 German aged, infirm, and retarded were killed in gas chambers there was no outcry from that medical profession either, and it was not far from there to Auschwitz.

I am concerned because at the moment we talk chiefly about morals and about ethics but what is going to happen when we add economics? It might be hard

enough for me to survive if I am a social burden but if I am a social burden *and* an economic burden, no matter how precious life might be to me, I don't have a chance.

Let it never be said by an historian in the latter days of this century that after the Supreme Court decided on abortion in 1973, infanticide began to be practiced without an outcry from the medical profession.

Let it not be said by that historian that perhaps the entering wedge was the decision on the part of pediatricians that there were some burdens too great to be borne by families and that a far better solution to the burden was infanticide of a child who was either unwanted by those parents or who would produce social problems and emotional distress in the family and in society.

Let it not be said that the entering wedge was the infanticide of a portion of the neonatal population of our teaching hospitals' intensive care units.

Let it not be said that pediatric surgeons of this country, who have perhaps the greatest experience and the greatest understanding of what can be done with a deformed life, not just in the correction of mechanical problems but in the rehabilitation of a family, stood by while these things happened and said nothing.

Let it not be said by that historian that in the third quarter of the twentieth century physicians were so concerned with perfect children that the moral fiber of our profession and of our country was irreparably damaged because we had forgotten how to face adversity.

Let it not be said that the extermination programs for various categories of our citizens could ever have come about if the physicians of this country had stood for the moral integrity that recognizes the worth of every human life.

CONCLUSION

A first step toward finding an unenumerated Constitutional Right to kill might start a slide to Auschwitz.

Respectfully submitted,

ROBERT L SASSONE

Attorney for amicus

NO 88-1503
IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1989

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L AND JOYCE CRUZAN
Petitioners,

v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,
Respondents,

v.

THAD C. McCANSE, GUARDIAN AD LITEM,
Respondent.

Affidavit of mailing of amicus brief copies, Rule 28.2

State of California }ss.
City of Santa Ana, County of Orange }

Robert L Sassone, being first duly sworn on his oath deposes and says:

Robert L Sassone is a member of the bar of the United States Supreme Court admitted October 26, 1971. To his knowledge, on October 11, 1989, within the particular time and permitted time for serving of said amicus brief pursuant to Rule 28.2, he deposited in the United States Mailbox at Santa Ana, CA 92701 pursuant to Rule 28.2 with first class postage prepaid 40 copies of the attached amicus brief in the present case properly addressed to the Clerk of the United States Supreme Court and three copies of said amicus brief to each party addressed as follows:

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ROBERT L SASSONE, Affiant,

Subscribed and sworn to before me on
October 11, 1989,

_____

Lawrence D Sassone, Notary Public